

12397

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Maryland</i> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>X</i>		LENGTH OF STAY (in this place) <i>15 months</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i>			
TOWN <i>Telegraphman</i>				TOWN <i>Portsmouth</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>300 Pearl St</i>		<i>1</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <i>Bernard</i> <i>Ball</i>				OF DEATH: <i>Dec 17, 1955</i>			
5. SEX: <i>m.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>Feb. 4 1898</i>	9. AGE last birthday <i>57</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>carries</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Canning</i>		11. BIRTHPLACE (State or foreign country): <i>Portsmouth Va</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Unknown</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>Unknown</i>				16. SOCIAL SECURITY NO. <i>228-24-4354</i>		17. INFORMANT & ADDRESS: <i>Lucy Ball Telegraphman Ind.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.0</i> (A) <i>cardiac weakness</i>						<i>4 mos</i>	
ANTECEDENT CAUSE (B) <i>arteriosclerosis</i>						<i>1 yr</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov</i> , 19 <i>55</i> , to <i>Dec 17</i> , 19 <i>55</i> that I last saw the deceased alive on <i>Dec 16</i> , 19 <i>55</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wm. R. Reddy</i>				DATE SIGNED <i>Dec 18 1955</i>			
M.D. <i>Wm. R. Reddy</i>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>buried - stored</i>		<i>1/3 1956</i>		<i>Univ. of Md. Med. School</i>		<i>Baltimore, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>JAN 10 1956</i>		<i>Wm. R. Reddy</i>		<i>Lucy Ball Telegraphman</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12548

BUREAU V. S.

JAN 11 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12367 CERTIFICATE OF DEATH

12349

Item 7, Film G190 12-23-55 et

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		STATE <u>Md</u>		COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>5 days 6 hrs 25 min</u>		TOWN <u>Stall Pond</u>		<u>14X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Annie</u> (Middle) <u>Baxter</u> (Last)				(Month) (Day) (Year)			
				<u>December 5 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>January 20 1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wilcox Ziesel</u>				<u>Josephine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
				<u>Mr Norman Baxter (son)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ruptured arteriosclerotic plaque.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Easton</u>		DATE SIGNED <u>Dec. 1955</u>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 8 1955</u>		<u>Chesler Cemetery</u>		<u>Chesler Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12/7/55</u>		<u>N.A. Neerues</u>		<u>Marvin V. Williams</u>		<u>Chesler, Md</u>	

12368

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>123 Locust st</u>				STREET ADDRESS (If rural give location) <u>123 Locust</u>		<u>1</u>	
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Mable</u>		(Middle)		(Last) <u>Beamus</u>		DATE OF DEATH: <u>12</u> <u>17</u> 19 <u>55</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Col</u>		7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>7/21/1906</u>	
9. AGE last birthday <u>55</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>John Beamus</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Hicks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Remona Moore Easton, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of Cervix</u>						<u>1 year</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>18/5/55</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Ca of Cervix (Squamous cell)</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/5/55</u> 19....., to <u>12/17</u> , 19 <u>55</u> that I last saw the deceased alive on <u>12/16</u> , 19 <u>55</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J.T.B. Ambler</u>				ADDRESS <u>M.D. Easton, Md.</u>		DATE SIGNED <u>12/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>12/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>	
LOCATION (City, town, or county) (State) <u>Easton, MD.</u>							
DATE REC'D BY LOCAL REGISTRAR <u>12-21-55</u>				REGISTRAR'S SIGNATURE <u>N.H. Neerice</u>		24. FUNERAL DIRECTOR ADDRESS <u>James D. Doherty, Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12369 CERTIFICATE OF DEATH

12351

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>40 Easton</u>		<u>Life</u>		TOWN <u>Easton</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>202 Port st.</u>				STREET ADDRESS (If rural give location) <u>4210 Dover st.</u>			
3. NAME OF DECEASED (Type or Print) <u>Sheryl E Bently</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 1 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>ca</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>9/12/55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>2</u> yrs.		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wendell Bently</u>		14. MOTHER'S MAIDEN NAME <u>Elaine Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs Elaine Taylor</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>1-2 hours</u>			
762.0 IMMEDIATE CAUSE (A) <u>Asphyxia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1</u> 19 <u>55</u> , to <u>12/1</u> 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> 19 <u>55</u> , and that death occurred at <u>8 A</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>Raymond T. Melt</u> M.D.				ADDRESS (Street, city, town, state) <u>6330 Waverly St. Easton, MD</u>			
DATE <u>12/5/55</u>				DATE SIGNED <u>12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		LOCATION (City, town, or county) <u>Easton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>M. H. Newberry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u>		ADDRESS <u>Easton, Md.</u>	

4095192405

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12352

12370

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>talbot</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
40 TOWN <u>Easton</u>		<u>Life</u>		40 TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hammond st</u>				STREET ADDRESS (If rural give location) <u>Hammond</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>westley</u> (Last) <u>Blackson</u>				(Month) <u>Dec.</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>Col</u>	<u>Married</u>	<u>6/15/76</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Laborer</u>			<u>Domestic</u>		<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John W. Johnson</u>				<u>Mary S. Gibbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) <u>Carcinoma of prostate gland</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-2 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 26</u> , 19 <u>55</u> , to <u>Dec. 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 3</u> , 19 <u>55</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above. <u>12/5/55</u>							
SIGNATURE <u>Hayward T. Helt</u> M.D.				ADDRESS (Street, city, town, state) <u>633 Hurst St. Easton MD</u> DATE SIGNED <u>12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/6/55</u>		<u>Richards Cem.</u>		<u>Easton, md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-5-55</u>		<u>N.H. Nevers</u>		<u>James D. Daskell</u>		<u>Easton, md.</u>	

1. The first step in the process of identifying a problem is to define the problem. This involves identifying the symptoms of the problem and determining the scope of the problem. Once the problem has been defined, the next step is to identify the causes of the problem. This involves identifying the factors that are contributing to the problem and determining the underlying causes. Once the causes have been identified, the next step is to develop a plan of action. This involves identifying the steps that need to be taken to address the problem and determining the resources that will be needed to implement the plan. Once a plan of action has been developed, the next step is to implement the plan. This involves carrying out the steps that have been identified in the plan and monitoring the progress of the implementation. Finally, the last step in the process is to evaluate the results of the implementation. This involves assessing the effectiveness of the plan and determining whether the problem has been resolved.

BUREAU V.

DEC 9 1955

RECEIVED

12371

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Talbot		MARYLAND		STATE Md.		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Easton		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Easton Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last) Thomas Elwood Blades				4. DATE (Month) (Day) (Year) OF DEATH: Dec. 2 1955			
5. SEX: Male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH: July 3, 1920	
9. AGE last birthday 35 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): St. Michaels Utilities - Linesman				10B. KIND OF BUSINESS OR INDUSTRY: Caroline Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Wm. Milton Blades				14. MOTHER'S MAIDEN NAME: Florence Foster			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) World War I				16. SOCIAL SECURITY NO. 212 -18 - 6596		17. INFORMANT & ADDRESS: Clyde Blades Easton, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
819X IMMEDIATE CAUSE (A) Structural skull - penetrating						Immediate	
ANTECEDENT CAUSE (S) DUE TO Auto accident							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Road		21C. WHERE DID (City or town) INJURY OCCUR? Easton Md		(County) (State) Talbot Md	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 12 2 55 11 30 P.M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? Pass. in car which struck tree			
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE L. M. White		M. D. Easton Md		DATE SIGNED 12-3-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 12-5-55		NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		LOCATION (City, town, or county) (State) Easton, Talbot Md.	
DATE REC'D BY LOCAL REGISTRAR 12/3/55		REGISTRAR'S SIGNATURE N.H. Newnam		24. FUNERAL DIRECTOR ADDRESS Maurice E. Newnam & Son Easton, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 9 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
12372 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

12354

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> LENGTH OF STAY (In this place) <u>D.O.A.</u> TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u> TOWN <u>Grasonville</u> (If rural, give location) <u>17X-2</u> STREET ADDRESS <u></u>													
3. NAME OF DECEASED (Type or Print) <u>Bruce</u> (First) <u>Carter</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>14</u> (Year) <u>1955</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>		8. DATE OF BIRTH <u>9-10-1955</u>		9. AGE last birthday <u>4 months</u>		If under 1 year Months Days Hours Min. If under 24 hrs. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Welford Carter</u>						14. MOTHER'S MAIDEN NAME <u>Thelma Gray</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY No.						17. INFORMANT AND ADDRESS					
18. MEDICAL CERTIFICATION																	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 490X Immediate cause (a) <u>This baby was dead on arrival at hospital - It was evidently Labor Pneumonia</u> Antecedent cause(s) (b) <u>short duration</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)												INTERVAL BETWEEN ONSET AND DEATH					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.																	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY				(CITY OR TOWN)				(COUNTY)		(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				HOW DID INJURY OCCUR?									
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>noturol causes</u> <input type="checkbox"/> <u>accident</u> <input type="checkbox"/> <u>suicide</u> <input type="checkbox"/> <u>homicide</u> <input type="checkbox"/> <u>undetermined</u> <input checked="" type="checkbox"/> <u>Cauterized</u> SIGNATURE (Degree or title) <u>W. Henry Fisher M.D. Deputy Med Exam for 2nd & 3rd</u> ADDRESS <u>Chester</u> DATE SIGNED <u>11/14/55</u>																	
23. BURIAL, CREMATION <u>BURIAL</u> (Specify)				DATE THEREOF <u>Dec 15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Morgnetic Cemetery</u>				LOCATION (City, town, or county) <u>Chester</u> (State) <u>Town</u>							
DATE REC'D BY LOCAL REG. <u>12-14-55</u>				REGISTRAR'S SIGNATURE <u>N.A. Neeress</u>				24. FUNERAL DIRECTOR <u>J. Carl Boyer</u> ADDRESS									

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 23 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12355

12373

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>3da.</u>		TOWN <u>Easton</u>		<u>49</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>407 August St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>ASA</u>		(Middle)		(Last) <u>Cohee</u>		<u>12-18</u> 19 <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec 9, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Cohee</u>				14. MOTHER'S MAIDEN NAME <u>Emily Dill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Cora Cohee</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4201 IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>				<u>Coronary thrombosis.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Easton Talbot Co. Md.</u>		DATE SIGNED <u>70 Dec 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>12/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton (Talbot Co.) Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS	
DATE <u>12-20-55</u>							

CERTIFICATE OF DEATH

1. DEATH OF DEATH

2. DEATH OF DEATH

3. DEATH OF DEATH

4. DEATH OF DEATH

5. DEATH OF DEATH

6. DEATH OF DEATH

7. DEATH OF DEATH

8. DEATH OF DEATH

9. DEATH OF DEATH

10. DEATH OF DEATH

11. DEATH OF DEATH

12. DEATH OF DEATH

13. DEATH OF DEATH

14. DEATH OF DEATH

15. DEATH OF DEATH

16. DEATH OF DEATH

17. DEATH OF DEATH

18. DEATH OF DEATH

19. DEATH OF DEATH

20. DEATH OF DEATH

21. DEATH OF DEATH

22. DEATH OF DEATH

23. DEATH OF DEATH

24. DEATH OF DEATH

25. DEATH OF DEATH

26. DEATH OF DEATH

27. DEATH OF DEATH

28. DEATH OF DEATH

29. DEATH OF DEATH

30. DEATH OF DEATH

31. DEATH OF DEATH

32. DEATH OF DEATH

33. DEATH OF DEATH

34. DEATH OF DEATH

35. DEATH OF DEATH

36. DEATH OF DEATH

37. DEATH OF DEATH

38. DEATH OF DEATH

39. DEATH OF DEATH

40. DEATH OF DEATH

41. DEATH OF DEATH

42. DEATH OF DEATH

43. DEATH OF DEATH

44. DEATH OF DEATH

45. DEATH OF DEATH

46. DEATH OF DEATH

47. DEATH OF DEATH

48. DEATH OF DEATH

49. DEATH OF DEATH

50. DEATH OF DEATH

51. DEATH OF DEATH

52. DEATH OF DEATH

53. DEATH OF DEATH

54. DEATH OF DEATH

55. DEATH OF DEATH

56. DEATH OF DEATH

57. DEATH OF DEATH

58. DEATH OF DEATH

BUREAU V. S.

JEC 28 1955

RECEIVED

12-10-1955

12374

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <i>Easton</i>		<i>1 day - 19 hrs</i>		TOWN <i>Easton Rd #1 - Box 224</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Jacqueline De Shields</i>				<i>12 24 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<i>F</i>	<i>Cloud</i>	<i>5</i>	<i>11-11-55</i>		<i>1</i>	<i>13</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Herbert De Shields</i>				<i>Evelyn Harris</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:			
<i>No</i>				<i>Herbert De Shields</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Pyelonephritis</i>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/22</i> , 19 <i>55</i> , to <i>12/24</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/24</i> , 19 <i>55</i> , and that death occurred at <i>3:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		M. D. <i>[Signature]</i>		ADDRESS <i>Easton</i>		DATE SIGNED <i>30 Dec 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12-26-55</i>		<i>Unionville</i>		<i>Easton Md RD 7</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>12-25-55</i>		<i>N.H. Neuman</i>		<i>J.B. Rashell</i>		<i>Easton</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12357

12375

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>1 hr. 5 min.</u>		TOWN <u>Easton</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby Girl Edwards</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>19</u> <u>55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>12-19-55</u>	
						9. AGE last birthday <u>7</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>1</u> <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Lawrence Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Adeline Edwards</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
176X IMMEDIATE CAUSE (A) <u>Anoxemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 5 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Left Ovary Cystic. Removal Sept 55 - Corpus luteum in the ovary.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Birth weight 22 oz.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>Refused</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-19-55</u> to <u>12-19-55</u> , that I last saw the deceased alive on <u>12-19-55</u> , and that death occurred at <u>2:40</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Ch. F. Buell</u>				ADDRESS (Street, city, town, state) <u>Easton Md</u>		DATE SIGNED <u>12-20-55</u>	
M.D. <u>Easton</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Richards</u>		LOCATION (City, town, or county) (State) <u>Easton Md</u>	
24. REC'D BY REGISTRAR <u>12/20/55</u>		REGISTRAR'S SIGNATURE <u>H. H. Neerue</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James Blackwell</u>		ADDRESS <u>Easton, Md.</u>	

20V5253240

CERTIFICATE OF DEATH

Form No. 1

1. Usual Residence of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Manner of Death

6. Age at Death

7. Sex

8. Race

9. Marital Status

10. Occupation

11. Education

12. Date of Birth

13. Date of Admission to Hospital

14. Date of Discharge from Hospital

15. Date of Death

16. Date of Burial

17. Date of Interment

18. Date of Cremation

19. Date of Disposition

20. Date of Final Disposition

21. Date of Final Disposition

22. Date of Final Disposition

23. Date of Final Disposition

24. Date of Final Disposition

25. Date of Final Disposition

26. Date of Final Disposition

27. Date of Final Disposition

28. Date of Final Disposition

29. Date of Final Disposition

30. Date of Final Disposition

BUREAU V. S.

DEC 28 1955

RECEIVED

NOTIFICATION

1
The following information is being furnished to you for your information and for the use of the State Department of Health, Baltimore, Maryland. It is requested that you keep this information confidential and not disclose it to any other person. If you have any questions or need further information, please contact the State Department of Health, Baltimore, Maryland. This information is being furnished to you for your information and for the use of the State Department of Health, Baltimore, Maryland. It is requested that you keep this information confidential and not disclose it to any other person. If you have any questions or need further information, please contact the State Department of Health, Baltimore, Maryland.

12376

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Talbot</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>20 EASTON</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>100 EASTON Grassville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>17X-2</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>FASSETT</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Dec 18 1955</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>12-18-55</i>
9. AGE last birthday: <i>0</i> yrs.		10. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Md.</i>
13. FATHER'S NAME: <i>Littleton H. Fasset</i>		14. MOTHER'S MAIDEN NAME: <i>Mable P. Lockwood</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS: <i>Ida H. Brooks - Easton</i>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>759.8 Congenital dyscrasia</i>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE <i>Louis M. M. C.H.O.</i>		ADDRESS <i>Easton Md</i>	
DATE SIGNED <i>12-20-55</i>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <i>Buried</i>		DATE THEREOF <i>12/19/55</i>	NAME OF CEMETERY OR CREMATORY <i>Grassville</i>
LOCATION (City, town, or county) (State) <i>Grassville Md</i>			
DATE REC'D BY LOCAL REGISTRAR <i>12/19/55</i>		REGISTRAR'S SIGNATURE <i>N. H. Newier</i>	
24. FUNERAL DIRECTOR <i>Littleton H. Fasset</i>		ADDRESS <i>Grassville</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 10 1956

RECEIVED

Item 9, Film 191 1-11-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 290

12377

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Talbot</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<i>40 Easton (Rural)</i>	<i>Entire life</i>	<i>Easton (Rural)</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>Memorial Hospital</i>		<i>Rappe</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<i>Earle Thomas Foster Jr.</i>		<i>Dec 24 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>M</i>	<i>W</i>	<i>married</i>	<i>7 Nov. 12, 1924</i>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<i>31 3/8 yrs.</i>		<i>U.S.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>Logging</i>		<i>Lumumba</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Earle Foster</i>		<i>Kath Paulkner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>none</i>	
17. INFORMANT & ADDRESS:			
<i>Earle Foster (Father)</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Brain damage</i>			<i>Immediate</i>
ANTECEDENT CAUSE (S) DUE TO (B) <i>Fracture skull</i>			<i>11</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>Dec 24 1955</i>		<i>Fracture skull</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
<input type="checkbox"/>		<i>Home</i>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
<i>Easton, Talbot</i>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
<i>Dec 24 1955 M.</i>		<i>Auto</i>	
22. I hereby certify that I attended the deceased from , 19..... , to , 19..... , that I last saw the deceased alive on , 19..... , and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>Dr. C. A. Kummer M.D.</i>		<i>27 Dec 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Springhill Cemetery</i>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR (ADDRESS)	
<i>12/26/55</i>		<i>M.E. Newman + Son Easton Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1956

BUREAU V. S.

12378

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Talbot MARYLAND			STATE Md. COUNTY Talbot		
CITY (If outside corporate limits, write RURAL OR and give nearest town) Easton			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Trappe		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital			STREET ADDRESS (If rural give location) /		
3. NAME OF DECEASED: (First) (Middle) (Last) Harry Parkes Harris			4. DATE (Month) (Day) (Year) OF DEATH: Dec. 24 19 55		
5. SEX: Male	6. COLOR OR RACE: white	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: June 2, 1933		9. AGE last birthday 22 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): labor			10B. KIND OF BUSINESS OR INDUSTRY: farm labor		11. BIRTHPLACE (State or foreign country): Talbot Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S.			13. FATHER'S NAME: William T. Harris		
14. MOTHER'S MAIDEN NAME: Sallie R. Parks			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 214-32-6400			17. INFORMANT & ADDRESS: Mrs. Sallie R. Parks Harris Trappe, Md.		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) Brain Damage					Immediate
ANTECEDENT CAUSE (B) Fracture Skull					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: Dec 24 1955		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? 20	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Dec 24 1955 M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Auto	
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at M, from the causes and on the date stated above.					
SIGNATURE D. O. A.		ADDRESS 27 Dec 58		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 12-27-55		NAME OF CEMETERY OR CREMATORY Windy Hill Cemetery	
LOCATION (City, town, or county) (State) Trappe, Talbot Maryland.		24. FUNERAL DIRECTOR ADDRESS Maurice E. Newnam & Son Easton, Md.			
DATE REC'D BY LOCAL REGISTRAR 12/26/55		REGISTRAR'S SIGNATURE M. A. Newnam			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12379 CERTIFICATE OF DEATH

12360

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 TOWN <u>Easton</u>		Life		TOWN <u>Easton</u>		40	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
08 <u>107 Port st.</u>				<u>107 Port st.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William E.</u> (Middle) <u>Harris</u> (Last)				(Month) <u>12</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Col</u>	<u>Married</u>	<u>4/28/02</u>	<u>53</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Domestic</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Harris</u>				<u>Kattie Gale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>9</u>		<u>165-12-1537</u>		<u>Mrs. Anna Harris Easton Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
238X IMMEDIATE CAUSE (A) <u>Tumor of Cervical Vertebra - of unknown origin</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Multiple pulmonary abscesses -</u>				2-3 da			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>None</u>		<u>None</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<u>None</u>							
22. I hereby certify that I attended the deceased from <u>6-15</u> , 19 <u>55</u> , to <u>12-6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-5</u> , 19 <u>55</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William R. Winter</u>				ADDRESS (Street, city, town, state) <u>Easton MD</u>			
M.D.				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/10/55</u>		<u>Richards</u>		<u>Easton MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 14 1955</u>		<u>Mrs. N. L. Morris</u>		<u>James B. Doherty</u>		<u>Easton Md.</u>	

1875 CERTIFICATE OF DEATH

Form No. 100

A. Usual Residence of Deceased

B. Date of Death

C. Age of Deceased

D. Sex of Deceased

E. Race of Deceased

F. Cause of Death

G. Place of Death

H. Signature of Physician

I. Signature of Registrar

J. Date of Registration

K. Name of Registrar

L. Name of Physician

M. Name of Informant

N. Name of Informant

O. Name of Informant

P. Name of Informant

Q. Name of Informant

R. Name of Informant

S. Name of Informant

T. Name of Informant

U. Name of Informant

V. Name of Informant

W. Name of Informant

X. Name of Informant

Y. Name of Informant

Z. Name of Informant

BUREAU V. S.

DEC 14 1955

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12594
 Item 14, Film G191 1-16-56 et
 12380 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Easton</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cordova</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Samuel</u> (Middle) <u>Joseph</u> (Last) <u>Hopkins</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>31</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Sept. 12, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Mr. William Hopkins</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS: <u>Mrs. Bessie Hopkins (wife)</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
446X IMMEDIATE CAUSE (A) <u>sepsis</u>			DUE TO				(?)
ANTECEDENT CAUSE (B) <u>chronic obstructive nephropathy</u>			DUE TO				(?)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>28th</u> , 1955, to <u>31st</u> , 1955, that I last saw the deceased alive on <u>Dec. 31</u> , 1955, and that death occurred at <u>11:52</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Thos. Tan Harrison</u>			M.D. <u>Carlton Mayland</u>		DATE SIGNED <u>Jan 56</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Bureau</u>		DATE THEREOF <u>1/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-2-56</u>		REGISTRAR'S SIGNATURE <u>N.H. Neer</u>		24. FUNERAL DIRECTOR <u>J.E. Boulaes</u>		ADDRESS <u>Greensboro Md.</u>	

UNITED STATES OF AMERICA

VALLEY'S
CONGRESS
BOND

BUREAU V. 1

JAN 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12, Film G190, 12/12/55 bh

12398 **CERTIFICATE OF DEATH**

12361

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bozman rural</u>				OR TOWN <u>Bozman</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Carroll</u> (Middle) <u>Jefferson</u> (Last)				12 1 1955			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
						9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Unknown</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to..... 19....., that I last saw the deceased alive on 19....., and that death occurred at M. from the causes and on the date stated above.							
SIGNATURE <u>Louis Whitty DME</u> M.D.				ADDRESS (Street, city, town, state) <u>Easton Md</u> DATE SIGNED <u>12-2-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
				<u>Anatomy Board of Md.</u>		<u>Univ. of Md. Medical School.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DEC 5 1955		<u>N. H. Morris</u>		<u>Norman V. Marshall</u>			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form 100-1-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CLERK

19. SIGNATURE OF ASSISTANT CLERK

20. SIGNATURE OF CHIEF CLERK

21. SIGNATURE OF DEPUTY CHIEF CLERK

22. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF ASSISTANT CLERK IN CHARGE

25. SIGNATURE OF CLERK IN CHARGE

26. SIGNATURE OF ASSISTANT CLERK IN CHARGE

27. SIGNATURE OF CLERK IN CHARGE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CLERK

19. SIGNATURE OF ASSISTANT CLERK

20. SIGNATURE OF CHIEF CLERK

21. SIGNATURE OF DEPUTY CHIEF CLERK

22. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF ASSISTANT CLERK IN CHARGE

25. SIGNATURE OF CLERK IN CHARGE

26. SIGNATURE OF ASSISTANT CLERK IN CHARGE

27. SIGNATURE OF CLERK IN CHARGE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CLERK

19. SIGNATURE OF ASSISTANT CLERK

20. SIGNATURE OF CHIEF CLERK

21. SIGNATURE OF DEPUTY CHIEF CLERK

22. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF ASSISTANT CLERK IN CHARGE

25. SIGNATURE OF CLERK IN CHARGE

26. SIGNATURE OF ASSISTANT CLERK IN CHARGE

27. SIGNATURE OF CLERK IN CHARGE

BUREAU V. S.

DEC 6 1955

RECEIVED

3101717-1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12399 CERTIFICATE OF DEATH

12362

Reg. Dist. No. 290

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>TALBOT</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>TALBOT</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON - RURAL 5 1/2 MS.</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>RURAL</u>	
3. NAME OF DECEASED (Type or Print) <u>NANNIE JOHNSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 15 1955</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MAR. 6, 1888</u>
9. AGE last birthday <u>67</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Isaac Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Copper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Mary Ethel Morrey, Easton, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Hypertensive Crisis with cerebral vascular disease</u>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 12</u>, 19<u>55</u>, to <u>Dec 15</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec 12</u>, 19<u>55</u>, and that death occurred at <u>Easton, Md.</u> from the causes and on the date stated above.			
SIGNATURE <u>Louis M. Mitty</u>		DATE SIGNED <u>12-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-18-55</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>N. A. Neerues</u>		ADDRESS (Street, city, town, state) <u>Easton Md</u>	
DATE <u>12-18-55</u>		ADDRESS <u>Coppersville, T. L. H. Co.</u>	

12381

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40</u> <u>Easton, Md.</u>		LENGTH OF STAY (If in this place) <u>48 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Federalburg, Md.</u> <u>25X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80</u> <u>Easton Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>323 Buena Vista Ave.</u> ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
(First) <u>Ida</u> (Middle) <u>R.</u> (Last) <u>Lane</u>				OF DEATH: <u>12</u> <u>27</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 25, 1879</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>N.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Seaward Nichols</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Nichols</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Harvey Williams - Federalburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>175X</u> <u>Intestinal Obstruction</u>							
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Carcinoma of ovary</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/10</u> , 19 <u>55</u> , to <u>12/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>55</u> , and that death occurred at <u>12:40</u> M. from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS <u>608</u> DATE SIGNED <u>30 Dec 1955</u> M. D. <u>Coston</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-28-55</u>		REGISTRAR'S SIGNATURE <u>N.A. Newer</u>		24. FUNERAL DIRECTOR ADDRESS <u>Harvey Williams - Federalburg, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONTINUATION OF DEATH

DEPARTMENT OF HEALTH

MAILED
JAN 6 1956
U.S. DEPT. OF HEALTH

BUREAU V. S.

JAN 6 1956

RECEIVED

12332 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 <i>Easton, Md.</i>		3 days		Royal Oak, Md. X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <i>Memorial Hosp.</i>				/			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Carrie</i>				<i>Leonard</i>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):		8. DATE OF BIRTH:	
<i>Female</i>		<i>White</i>		<i>Single</i>		<i>Feb 24 / 1863</i>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<i>92</i> yrs.		Months		Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<i>Maryland</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>MR Nichols Leonard</i>				<i>Mary Ellen Hampton</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<i>Mrs. Marian Ferguson (niece)</i> <i>Royal Oak, Md.</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <i>Apoplexy</i>						4 days	
ANTECEDENT CAUSE (B) <i>HCVD</i>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>12/21</i> , 19 <i>55</i> , to <i>12/24</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/24</i> , 19 <i>55</i> , and that death occurred at <i>12:45</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				DATE SIGNED			
M. D. <i>Easton Md</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12/26/55</i>		<i>Springhill Cemetery</i>		<i>Easton, Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>12-25-55</i>		<i>N. H. Neer</i>		<i>Hampden</i>		<i>Harrison, St. Michaels Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1935 CERTIFICATE OF DEATH

RECEIVED STATE DEPARTMENT OF HEALTH - CALIFORNIA

VALLEY'S
CONGRESS
BOND

BUREAU V. S.

JAN 2 1936

RECEIVED

12365

MARYLAND STATE DEPARTMENT OF HEALTH

12383

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 290

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Denton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hos</u>		STREET ADDRESS (If rural, give location) <u>Second St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Calvert</u>	(Middle) <u>C.</u>	(Last) <u>Merriken</u>
4. DATE OF DEATH	(Month) <u>12</u>	(Day) <u>21</u>	(Year) <u>1955</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 9 - 1987</u>
9. AGE last birthday <u>68</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry R. Merriken</u>		14. MOTHER'S MAIDEN NAME <u>Ella Conkran</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Jesse Rose Merriken</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>976X Cerebral Hemorrhage. Shock.</u>			<u>9 hrs.</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Gun shot wound to head.</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u> (CITY OR TOWN) <u>Denton</u> (COUNTY) <u>Caroline</u> (STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-24-55</u> P.m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Shot self with Pistol</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Samuel D. George MD</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>	
DATE REC'D BY LOCAL REG. <u>12-24-55</u>		24. FUNERAL DIRECTOR <u>J. P. Brown, Denton</u>	

RECEIVED

DEC 28 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12366

12384

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton, Md.</u>		<u>1.5 hrs.</u>		TOWN <u>St. Michaels</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Julia</u> (Middle) <u>Louise</u> (Last) <u>Miller</u>				<u>12-14-1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Dec. 30, 1865</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Sweden</u>	12. CITIZEN OF WHAT COUNTRY? <u>Sweden</u>		
13. FATHER'S NAME <u>John Hildering</u>				14. MOTHER'S MAIDEN NAME <u>Martha Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Bishop Allen J. Miller</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic coronary disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/14/55</u> to <u>12/14/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/14/55</u> , 19 <u>55</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Easton Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Old Trinity Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dorchester Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>N.A. Neerius</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Theresa E. Neumann</u>		ADDRESS	
DATE <u>12-17-55</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. MEDICAL CERTIFICATION

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF DECEASED

20. SIGNATURE OF NEXT OF KIN

21. SIGNATURE OF SURVIVOR

22. SIGNATURE OF WITNESSES

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF CLERK

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF DEPUTY SHERIFF

29. SIGNATURE OF WITNESSES

30. SIGNATURE OF CORONER

31. SIGNATURE OF JURY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY SHERIFF

36. SIGNATURE OF WITNESSES

37. SIGNATURE OF CORONER

38. SIGNATURE OF JURY

39. SIGNATURE OF JUDGE

40. SIGNATURE OF CLERK

41. SIGNATURE OF SHERIFF

42. SIGNATURE OF DEPUTY SHERIFF

43. SIGNATURE OF WITNESSES

44. SIGNATURE OF CORONER

45. SIGNATURE OF JURY

46. SIGNATURE OF JUDGE

47. SIGNATURE OF CLERK

48. SIGNATURE OF SHERIFF

RECEIVED

RECEIVED
DEC 23 1935
BUREAU V. 1935
J. V. S.

12385

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>24 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>328 Power Street</u>			
3. NAME OF DECEASED: (First) <u>Henrietta</u> (Middle) <u>C.</u> (Last) <u>Ried</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>29</u> <u>1955</u>			
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Dec 1, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John Leonard</u>				14. MOTHER'S MAIDEN NAME: <u>Josephine Streets</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Granny Passon (Niece)</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 1953, to <u>12-29</u> , 1955, that I last saw the deceased alive on <u>Dec 29</u> , 1955, and that death occurred at <u>7:15</u> A M, from the causes and on the date stated above.							
SIGNATURE <u>Donald A. Bentley</u>				ADDRESS <u>Easton, Md.</u>		DATE SIGNED <u>12-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-30-55</u>		REGISTRAR'S SIGNATURE <u>M. D. Neekens</u>		24. FUNERAL DIRECTOR <u>Maureen E. Lewandowski</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

12400 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Talbot		MARYLAND		STATE Md.		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL and give nearest town) Oxford		LENGTH OF STAY (in this place) 18 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oxford			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Oxford				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) Daniel		(Middle) L.		(Last) Roach		OF DEATH: Dec. 20 19 55	
5. SEX: Male	6. COLOR OR RACE: white	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): married	8. DATE OF BIRTH: Nov. 20, 1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Eastern Shore Utilities				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Neb.	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME: James Roach			
14. MOTHER'S MAIDEN NAME: Honora Cahill				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): yes W. W. # 1			
16. SOCIAL SECURITY NO.: 216-07-7031				17. INFORMANT & ADDRESS: Mrs. Mabel Roach Oxford, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) BRONCHOGENIC CARCINOMA						6 months	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 12/19 , 19 55 , to Dec. 20 , 19 55 , that I last saw the deceased alive on 12/19 , 19 55 , and that death occurred at 3:55 P.M., from the causes and on the date stated above.							
SIGNATURE Shepard Kiecer Jr.				M. D. Easton, Md.		DATE SIGNED 12/21/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-23-55		NAME OF CEMETERY OR CREMATORY Oxford Cemetery		LOCATION (City, town, or county) (State) Oxford, Talbot, Md.	
DATE REC'D BY LOCAL REGISTRAR 12/21/55		REGISTRAR'S SIGNATURE N. H. Newnam		24. FUNERAL DIRECTOR ADDRESS Maurice E. Newnam & Son Easton, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12386 CERTIFICATE OF DEATH

12369

Reg. Dist. No. 290

Item 7. Film G191 1-5-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>40 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston R7D#1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>05X-2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Forest</u> (Middle) <u>Ferdinand</u> (Last) <u>Russell</u>				(Month) <u>12</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 21, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Mr. George M. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Emma G. Prairie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. R E Sheerin</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Chronic Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease & Hypertension</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>2/25</u> , 19 <u>53</u> , to <u>12/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 15</u> , 19 <u>55</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John A. P. [Signature]</u>				DATE SIGNED <u>12/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				DATE THEREOF <u>Dec. 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>	
24. REC'D BY REGISTRAR <u>N. H. Neekes</u>				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Leonard</u>	
DATE <u>12-19-55</u>				ADDRESS (Street, city, town, state) <u>Wilmington Del.</u>		ADDRESS	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 2 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12387

CERTIFICATE OF DEATH

12370

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Easton</i>		<i>3 days 16 hrs 55 m</i>		TOWN <i>Federalburg</i>		<i>05X-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>J. Clayton Satterfield</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>12 4 1955</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>		8. DATE OF BIRTH <i>May 12 1885</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <i>70</i> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Mr. John Satterfield</i>				14. MOTHER'S MAIDEN NAME <i>Martha Sullivan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>2 18-16-8461</i>		17. INFORMANT & ADDRESS <i>Mrs. Ola Satterfield (wife)</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <i>Federalburg, Md.</i>			
610X IMMEDIATE CAUSE (A) <i>Alumina</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Hypertrophy of prostate</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that attended the deceased from <i>11/30</i> , 19 <i>55</i> , to <i>12/4</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/4</i> , 19 <i>55</i> and that death occurred at <i>2:57 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. J. Bampton</i>				ADDRESS (Street, city, town, state) <i>Carleton</i> DATE SIGNED <i>4 Dec 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/7/55</i>		NAME OF CEMETERY OR CREMATORY <i>Steele Crest</i>		LOCATION (City, town, or county) (State) <i>Federalburg Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>N. H. Neerue</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Bampton</i> ADDRESS <i>Carleton, Federalburg, Md.</i>			
DATE <i>12/5/55</i>							

1955 CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF CHURCH

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF BURIAL PLACE

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF INTERVIEWER

46. SIGNATURE OF INTERVIEWER

47. SIGNATURE OF INTERVIEWER

48. SIGNATURE OF INTERVIEWER

49. SIGNATURE OF INTERVIEWER

50. SIGNATURE OF INTERVIEWER

51. SIGNATURE OF INTERVIEWER

52. SIGNATURE OF INTERVIEWER

53. SIGNATURE OF INTERVIEWER

54. SIGNATURE OF INTERVIEWER

55. SIGNATURE OF INTERVIEWER

56. SIGNATURE OF INTERVIEWER

57. SIGNATURE OF INTERVIEWER

BUREAU V. S.

DEC 13 1955

RECEIVED

SHORTLISTEN

COMMUNITY OF

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12371

12388

CERTIFICATE OF DEATH

Reg. Dist. No. 290

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		STATE <u>MARYLAND</u>		COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>EASTON</u>		<u>2 days</u>		TOWN <u>EASTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>MARIAN V.R. Schuyler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 20 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>divorced Jan 14 1896</u>		8. DATE OF BIRTH <u>5-9</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Sidney Schuyler</u>				14. MOTHER'S MAIDEN NAME <u>Corra Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. J. Ramsey Speer, Sr. Easton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
446X IMMEDIATE CAUSE (A) <u>Abdominal</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardiac hypertrophy</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., and that death occurred at <u>4:47 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Easton, Md.</u>		DATE SIGNED <u>20 Dec 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
24. REC'D BY REGISTRAR <u>12-22-55</u>		REGISTRAR'S SIGNATURE <u>N.H. Neer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of Deceased

2. Date of Death
3. Place of Death
4. Cause of Death

5. Age of Deceased
6. Sex of Deceased

7. Race of Deceased
8. Marital Status

9. Occupation of Deceased

10. Usual Residence of Deceased

11. Signature of Physician

12. Signature of Registrar

13. Signature of Coroner

14. Signature of Medical Examiner

15. Signature of Health Officer

16. Signature of County Clerk

17. Signature of Mayor

18. Signature of Town Clerk

19. Signature of Justice of the Peace

20. Signature of Notary Public

21. Signature of Minister of the Gospel

22. Signature of Other

BUREAU V. S.

DEC 28 1955

RECEIVED

12389

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>40</u> <u>Easton</u>		<u>8 days</u>		<u>40</u> <u>Easton, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>80</u> <u>Easton Memorial Hospital</u>				<u>408</u> <u>August Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Betty</u> <u>Sharp</u>				DATE OF DEATH: <u>Dec.</u> <u>29</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Sept 13</u> <u>1885</u>	<u>70</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Delaware</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James L. Andrew</u>				<u>Martha Wooters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Mrs Laura Patchett (sister)</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
451X IMMEDIATE CAUSE				<u>12/23/55</u>			
ANTECEDENT CAUSE (B)				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/29</u> , 19 <u>55</u> , to <u>12/29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>55</u> , and that death occurred at <u>8</u> <u>15</u> <u>A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED			
				M. D. <u>Easton</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/31/55</u>		<u>Kidgley Cemetery</u>		<u>Kidgley Cove, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-30-55</u>		<u>N.A. Neer</u>		<u>Maunice C. Newman</u>		<u>100</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

IAN 2 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12373

12390 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		STATE <u>MD</u> COUNTY <u>TALBOT</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>EASTON</u>		LENGTH OF STAY (In this place) <u>40 yrs.</u>		CITY OR TOWN <u>EASTON</u>		CITY OR TOWN <u>EASTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EARL AVE</u>				STREET ADDRESS (If rural give location) <u>EARL AVE</u>			
3. NAME OF DECEASED (Type or Print) <u>ETHEL ELIZABETH SIGMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 19 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>FEB. 12, 1887</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>THEODORE NASKEY</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Dorothy Newton Easton Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10 yrs	
443K IMMEDIATE CAUSE (A) <u>H.C.V.D.</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/11/55</u> , to <u>12/19/55</u> , that I last saw the deceased alive on <u>10/11/55</u> , and that death occurred at <u>3:32 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. G. Cox</u>				ADDRESS (Street, city, town, state) <u>Easton Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>SPRINGHILL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>EASTON TALBOT MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>M. D. Newton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>MAURICE E NEWNAM</u>		ADDRESS <u>Easton Md.</u>	
DATE <u>12/20/55</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF COURT

26. SIGNATURE OF JUDGE

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF CORONER

29. SIGNATURE OF JURY

30. SIGNATURE OF COURT

BUREAU V. S.

DEC 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12374

12391 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Caroline</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 TOWN <i>Easton</i>		3 days 3 hr		TOWN <i>Greensboro</i>		05x2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>W. Notle Sipple</i>				<i>12 19 55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>White</i>	<i>Married</i>	<i>Oct. 16, 1896</i>	<i>59</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Processing man</i>		<i>Pet milk Co.</i>		<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME <i>William Henry Sipple</i>				14. MOTHER'S MAIDEN NAME <i>Mary Addie Tothrock</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Mrs Anna Sipple</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443x IMMEDIATE CAUSE (A) <i>M7 Apoplexy</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>H-C-V.D.</i>				<i>2 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/16, 1955</i> , to <i>12/19, 1955</i> , that I last saw the deceased alive on <i>12/19, 1955</i> , and that death occurred at <i>10:25 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>V3</i>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<i>M.D. Easton Md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12/23/55</i>		<i>Greensboro</i>		<i>Greensboro, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>12-22-55</i>		<i>N.A. Neerix</i>		<i>J.E. Boulain</i>		<i>Greensboro, Md.</i>	

1901 CERTIFICATE OF DEATH

RECEIVED BY THE STATE DEPARTMENT OF HEALTH-BALTIMORE 10

A. J. JONES, JR. (Name of Deceased)

AGE 45
SEX Male
RACE White
BORN 1856
PLACE OF BIRTH Baltimore, Md.

DEATH

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BY

DATE

PLACE

CAUSE

DIAGNOSIS

BUREAU V. S.

DEC 28 1955

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12375

12392

CERTIFICATE OF DEATH

Reg. Dist. No. 290 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chester</u> <u>17X-2</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>40 EASTON</u>		LENGTH OF STAY (in this place) <u>16 days</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Memorial Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Joseph Richard Sparks</u>				OF DEATH: <u>12</u> <u>23</u> <u>19</u> <u>55</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>March 28-1879</u>	
9. AGE last birthday <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Gasoline Engineer</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Joseph Sparks</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Howell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>20</u>		17. INFORMANT & ADDRESS: <u>Mrs Naomi Crouch (Chester Md)</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of gastro-intestinal tract, site indeterminate</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION: <u>No operation</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/7</u> , 19 <u>55</u> , to <u>12/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>55</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. S. Noble</u>		M. D. <u>Easton Md</u>		DATE SIGNED <u>12/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-28-55</u>		<u>Chesterfield</u>		<u>Centerville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-25-55</u>		REGISTRAR'S SIGNATURE <u>N. A. Nevin</u>		24. FUNERAL DIRECTOR <u>Barton Bros. Centerville Maryland</u>		ADDRESS	

BUREAU V. S.

1956 2 NOV

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12393

12376

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton, Md.</u>		<u>17 hrs.</u>		TOWN <u>Bozman, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Theodore</u> (Middle) (Last) <u>Steilkie</u>				<u>12-14-1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct 17, 1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Waterman</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Gustavus Steilkie</u>				<u>Henrietta Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs Hattie Steilkie</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>myocardial infarction</u>				<u>36 hr</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic C.V.D.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1952, to 12-14-1955, that I last saw the deceased alive on 12-14-1955, and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>St Michaels Md</u>		DATE SIGNED <u>12-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/17/55</u>		<u>Bozman Cemetery</u>		<u>Bozman, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-17-55</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>St Michaels Md</u>	

BUREAU V. S.

DEC 23 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12394

CERTIFICATE OF DEATH

12377

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>25 yrs.</u>		TOWN <u>Easton, Maryland.</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Goldsboro St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Willy Hardcastle Stevens</u>				<u>Dec. 19, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>widowed</u>	<u>Nov. 4, 1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>School teacher</u>		<u>retired teacher</u>		<u>Mississippi.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>A. B. Hardcastle</u>				<u>Alice Hatch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Miss. Mary Hardcastle, Easton.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>491X</u> IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Upper Respiratory Infection</u>				<u>7 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General debility</u>				<u>yes</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rheumatoid Arthritis</u>				<u>yes</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1-1927</u>, to <u>12-19-1955</u>, that I last saw the deceased alive on <u>12-19-1955</u>, and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter J. Buell</u>				DATE SIGNED <u>12-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>12/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		LOCATION (City, town, or county) <u>Washington, D.C.</u>		(State)	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Buell</u>		26. ADDRESS <u>Easton Md</u>					

CERTIFICATE OF DEATH

Reg. Dist. 146

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. DATE OF BIRTH

9. TIME OF BIRTH

10. PLACE OF DEATH

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF BIRTH

14. DATE OF BIRTH

15. TIME OF BIRTH

16. PLACE OF DEATH

17. DATE OF DEATH

18. TIME OF DEATH

19. PLACE OF BIRTH

20. DATE OF BIRTH

21. TIME OF BIRTH

22. PLACE OF DEATH

23. DATE OF DEATH

24. TIME OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. TIME OF BIRTH

28. PLACE OF DEATH

29. DATE OF DEATH

30. TIME OF DEATH

31. PLACE OF BIRTH

32. DATE OF BIRTH

33. TIME OF BIRTH

34. PLACE OF DEATH

35. DATE OF DEATH

36. TIME OF DEATH

37. PLACE OF BIRTH

38. DATE OF BIRTH

39. TIME OF BIRTH

40. PLACE OF DEATH

41. DATE OF DEATH

42. TIME OF DEATH

43. PLACE OF BIRTH

44. DATE OF BIRTH

45. TIME OF BIRTH

46. PLACE OF DEATH

47. DATE OF DEATH

48. TIME OF DEATH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. TIME OF BIRTH

52. PLACE OF DEATH

53. DATE OF DEATH

54. TIME OF DEATH

55. PLACE OF BIRTH

56. DATE OF BIRTH

57. TIME OF BIRTH

58. PLACE OF DEATH

59. DATE OF DEATH

60. TIME OF DEATH

61. PLACE OF BIRTH

62. DATE OF BIRTH

63. TIME OF BIRTH

64. PLACE OF DEATH

65. DATE OF DEATH

66. TIME OF DEATH

67. PLACE OF BIRTH

68. DATE OF BIRTH

69. TIME OF BIRTH

70. PLACE OF DEATH

71. DATE OF DEATH

72. TIME OF DEATH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. TIME OF BIRTH

76. PLACE OF DEATH

77. DATE OF DEATH

78. TIME OF DEATH

79. PLACE OF BIRTH

80. DATE OF BIRTH

81. TIME OF BIRTH

82. PLACE OF DEATH

83. DATE OF DEATH

84. TIME OF DEATH

85. PLACE OF BIRTH

86. DATE OF BIRTH

87. TIME OF BIRTH

88. PLACE OF DEATH

89. DATE OF DEATH

90. TIME OF DEATH

91. PLACE OF BIRTH

92. DATE OF BIRTH

93. TIME OF BIRTH

94. PLACE OF DEATH

95. DATE OF DEATH

96. TIME OF DEATH

97. PLACE OF BIRTH

98. DATE OF BIRTH

99. TIME OF BIRTH

100. PLACE OF DEATH

101. DATE OF DEATH

102. TIME OF DEATH

103. PLACE OF BIRTH

104. DATE OF BIRTH

105. TIME OF BIRTH

106. PLACE OF DEATH

107. DATE OF DEATH

108. TIME OF DEATH

109. PLACE OF BIRTH

110. DATE OF BIRTH

111. TIME OF BIRTH

112. PLACE OF DEATH

113. DATE OF DEATH

114. TIME OF DEATH

115. PLACE OF BIRTH

116. DATE OF BIRTH

117. TIME OF BIRTH

118. PLACE OF DEATH

119. DATE OF DEATH

120. TIME OF DEATH

121. PLACE OF BIRTH

122. DATE OF BIRTH

123. TIME OF BIRTH

124. PLACE OF DEATH

125. DATE OF DEATH

126. TIME OF DEATH

127. PLACE OF BIRTH

128. DATE OF BIRTH

129. TIME OF BIRTH

130. PLACE OF DEATH

131. DATE OF DEATH

132. TIME OF DEATH

133. PLACE OF BIRTH

134. DATE OF BIRTH

135. TIME OF BIRTH

136. PLACE OF DEATH

137. DATE OF DEATH

138. TIME OF DEATH

139. PLACE OF BIRTH

140. DATE OF BIRTH

141. TIME OF BIRTH

142. PLACE OF DEATH

143. DATE OF DEATH

144. TIME OF DEATH

145. PLACE OF BIRTH

146. DATE OF BIRTH

147. TIME OF BIRTH

148. PLACE OF DEATH

149. DATE OF DEATH

150. TIME OF DEATH

151. PLACE OF BIRTH

152. DATE OF BIRTH

153. TIME OF BIRTH

154. PLACE OF DEATH

155. DATE OF DEATH

156. TIME OF DEATH

157. PLACE OF BIRTH

158. DATE OF BIRTH

159. TIME OF BIRTH

160. PLACE OF DEATH

161. DATE OF DEATH

REGISTERED

BUREAU V. 3

DEC 28 1955

RECEIVED

Handwritten signature and notes:
 Received from
 the Registrar
 of the
 State of Maryland
 for the
 year 1955

Handwritten notes and signatures at the bottom of the page.

12401

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>talbot</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Trappe</u>	<u>Life</u>	TOWN <u>Trappe</u> (Rural <input checked="" type="checkbox"/>)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Route 112</u>		<u>Rt 112</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Lorraine E.</u>	(Middle) <u>Thomas</u>	(Last) <u>Thomas</u>	
(Type or Print)		DATE OF DEATH: <u>12</u> <u>21</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12/1/55</u>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
yrs. <u>20</u>		Months <u>20</u>	Days <u>20</u> Hours <u>20</u> Min. <u>20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Earl Thomas</u>		<u>Marjorie Tilghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>9</u>		<u>—</u>	
17. INFORMANT AND ADDRESS:			
<u>Mr. Earl Thomas, Trappe, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>			
ANTECEDENT CAUSE (B) <u>491X</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>PM</u> , 19 <u>55</u> , to <u>12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/21/55</u> , and that death occurred at <u>12</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Louis M. M. M.</u>		DATE SIGNED <u>12-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Richards</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/23/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>James B. B. B.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12379

12395

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>11 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Trappe</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>DAISY</u> <u>WILSON</u>				<u>12</u> <u>26</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Nov. 6 - 1884</u>	9. AGE last birthday: <u>71</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Alex Brummell</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Lester Wilson (son)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>331X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cerebral Hemorrhage</u>							
(B) <u>Arteriosclerosis</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>12/15</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/15</u> , 19 <u>55</u> , to <u>12/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>55</u> , and that death occurred at <u>4:40 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED <u>30 Dec. 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/29/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Trappe Cemetery</u>		LOCATION (City, town, or county) (State) <u>Trappe, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/27/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Herbert M. St. Charles</u>		ADDRESS <u>Comb, Md.</u>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1956

NAME OF DECEASED

DATE OF DEATH

TOWN

AGE

SEX

CAUSE

DATE

VALLEY'S

ORIGINALS

RECORD

BUREAU V. S.

JAN 6 1956

RECEIVED

12396

CERTIFICATE OF DEATH

Reg. Dist. No. 290 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u> <u>058-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec.</u> <u>28</u> <u>1955</u>			
James L. Wright, Jr.							
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED , WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Nov. 1, 1922</u>	9. AGE last birthday: <u>33</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Merchant</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>James L. Wright, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Ida Timmons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						4 hours.	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Dec. 28, 1955</u> , to <u>Dec. 28, 1955</u> , that I last saw the deceased alive on <u>Dec. 28, 1955</u> , and that death occurred at <u>7:32 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. Paul Knotts</u>		M. D. <u>Denton Md</u>		ADDRESS <u>Denton Md</u>		DATE SIGNED <u>12-30-55</u>	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>Burial Dec. 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) <u>Denton, Md.</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>12-29-55</u>		REGISTRAR'S SIGNATURE <u>N. H. Neerues</u>		24. FUNERAL DIRECTOR <u>J. Virgil Swenson</u>		ADDRESS <u>Denton</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
1930 CERTIFICATE OF DEATH

BUREAU V. S.

JAN 10 1931

RECEIVED